GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

Hon Wanda Vázquez Garced
Gobernadora

Sra. Yolanda Garcia Lugo
Directora Ejecutiva Interina

September 16, 2019

Hon. Frank Pallone
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone:

Thank you for holding the critically important hearing entitled "Strengthening Health Care in the U.S. Territories for Today and Into the Future" on June 20, 2019. As the testimony presented by representatives of all the territories indicated, action by the federal government is needed in order to prevent a public health crisis in Puerto Rico and the sister territories.

Please find enclosed my responses to the questions for the record presented by the Committee. Please do not hesitate to contact me at the following phone number (787) 474-3344 or at ygarcia@asespr.org., if you require additional information.

Respectfully,

Yolanda García Lugo
Interim Executive Director

Attachment

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Additional Questions for the Record

Subcommittee on Health
Hearing on
"Strengthening Health Care in the U.S. Territories for Today and Into the Future"
June 20, 2019

Puerto Rico Health Insurance Administration

The Honorable Michael C. Burgess, M.D.

1. In FY 2018, federal spending for Medicaid in all five territories exceeded the annual Section 1108 allotment amount. I expect that in FY 2019, we'll see an increase in federal spending over the annual Section 1108 allotment amount for all five territories since they'll have access to a 100 percent federal matching rate for all or part of the fiscal year. Because no additional federal funding is available after December 2020, territories will generally need to finance any Medicaid spending over the annual Section 1108 allotment with local funds. My question for each of you is, if you only had the 1108 allotment funding, how short of funding would you all be?

All federal funding appropriated by the BBA and ACA will have expired on September 30, 2019 and December 31, 2019 respectively. At that time, Puerto Rico will rely on the Section 1108 capped funds and Enhanced Allotment Plan (EAP) funds to finance the Medicaid program. These funds are projected to be exhausted in the second quarter of federal fiscal year (FFY2020). After the exhaustion of the Section 1108 and EAP funds, the entirety of the program will need to be financed with state funds. Our projections are that for FFY2020, which begins October 1, 2019, the effective federal share for Medicaid and CHIP expenditures will be approximately 34%. For FFY2021 the effective federal share will fall below 20%. These estimates do not include the amounts for the measures that the Puerto Rico Government has identified as critical to stabilize, strengthen, and improve the Medicaid program and the island's healthcare system.

The following table shows the shortfall of funds assuming a 55% FMAP. The table also shows the projected 5-year Medicaid and critical sustainability measures expenditures. We also estimate the federal fund amounts for the section 1108 and EAP funds.

Puerto Rico Medicaid Request (Millions)						
Required Medicaid Federal Funds Estimate	**FFY2020**	**FFY2021**	**FFY2022**	**FFY2023**	**FFY2024**	**5-Yr Total**
Medicaid Baseline	$1,878.5	$1,952.1	$2,043.3	$2,139.6	$2,240.9	$10,254.5
Critical Sustainability Measures Federal Share	$367.8	$400.5	$395.7	$397.6	$407.0	$1,968.6
Total	$2,246.4	$2,352.6	$2,439.1	$2,537.2	$2,647.9	$12,223.1
Appropriated Medicaid Funds Projection						
Section 1108	$805.6	$379.2	$385.6	$392.2	$398.9	$2,361.5
EAP	$59.4	$62.5	$65.8	$69.3	$72.9	$329.9
Total	$865.0	$441.7	$451.4	$461.5	$471.8	$2,691.4
Federal Funds Shortfall	$1,381	$1,911	$1,988	$2,076	$2,176	$9,532

Note: The Section 1108 and EAP funds are projected. The grant amounts are calculated each year by HHS based on the change of the medical component of the CPI for Section 1108 and the Medicare Part D per capita growth for EAP funds.

The Honorable Gus M. Bilirakis

1. I understand that program funding in Puerto Rico comes from a variety of funding streams.

    a. Is this patchwork of funding conducive to proper oversight or does it create challenges and if so, what are some of those challenges?

The framework of patchwork funding presents multiple challenges for Puerto Rico, including hindering long-term strategic planning and proper program oversight, such as:

- *Puerto Rico cannot implement provider reimbursement rate increases over the long term to stem the exodus of providers and ensure availability of services in Puerto Rico.*
- *ASES has to delay program enhancements due to large upfront costs even though they might achieve savings in the long term, such as providing coverage for Hepatitis C drugs. These costly treatments require a significant initial investment which Puerto Rico is currently unable to afford without*

sustained federal assistance. In the long term, this investment is expected to result in savings to the Medicaid program through improved healthcare outcomes, reduced hospitalizations, and the avoidance of costly effects of not undergoing Hepatitis C treatment such as the development of cirrhosis, the need for dialysis, the need for liver transplants and associated immunosuppressant drugs, as well as avoiding the mental and emotional toll on patients suffering from these terrible complications. However, without a measure of predictability in the availability of funding from its federal partners, Puerto Rico cannot on its own afford the required initial investment.

- *The patchwork funding framework causes Puerto Rico to waste valuable financial resources on advisors and consultants as well as agency human resources to continually lobby congress for more federal funds.*

- *It also causes challenges when contracting Managed Care Organizations (MCOs) because they require guarantees from the Government that there is enough federal funding for the program.*

- *The Government of Puerto Rico must also comply with the requirements of the Financial Oversight and Management Board (FOMB) created under PROMESA, Pub. L. 114-187. As long as the amount of federal funding remains uncertain in the long term, it is impossible for the Government of Puerto Rico to establish long term policy goals with the FOMB that do not include the threat of benefit cuts or reducing the number of beneficiaries covered under the program. Questions such as whether additional benefits like pharmacy coverage or dental services will need to be eliminated from the program to comply with FOMB requirements will remain unanswered until stable economic funding for the Government Health Plan is secured.*

b. Puerto Rico's hospitals are eligible to receive DSH payments under Medicare. Can you briefly highlight the differences between Medicare DSH and Medicaid DSH?

The main difference between Medicaid and Medicare DSH payments for Puerto Rico, is that Puerto Rico does not receive Medicaid DSH payments, as it was excluded from Section 1923(f)(9) of the Social Security Act's definition of "State". It was also excluded from receiving a Medicaid DSH allotment per Section 1923(f)(2)(A) of the Social Security Act. Notably, Medicaid DSH allotments for years 2003 and thereafter are calculated based on the original allotments in (f)(2)(A), with adjustments as specified in (f)(3), such that the initial exclusion means that Puerto Rico hospitals continue to be excluded from the benefits of DSH payments, in spite of their dire need for the same.

The Medicaid DSH program is a joint federal-state program where additional payments are made to hospitals that serve a large number of Medicaid and low-income uninsured patients "to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients." (MACPAC, March 2014 Report to Congress). States have significant flexibility to structure their DSH program, for which reason DSH programs vary widely throughout the country, and the federal government reimburses each state for its share of DSH spending at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

States may specify in their State Medicaid Plans how funds are distributed to individual hospitals and which hospitals qualify for payments. However, states are required to include all hospitals that have: (1) a Medicaid inpatient utilization rate one standard deviation or more above the mean for all hospitals in the state, or (2) a low-income utilization rate exceeding 25 percent.

There are multiple annual limits to federal Medicaid DSH payments. The three most significant limits are:

1. *A limit on total annual federal DSH reimbursement to each state: The cap for each state is calculated based on its DSH allotment for the previous fiscal year (FY), adjusted for inflation.*
2. *A hospital-specific DSH limit: A hospital's DSH payments in a given year cannot exceed its net cost of providing care to Medicaid patients and the uninsured.*
3. *The ACA imposed annual reductions to each state's DSH limit. The imposition of those reductions have been delayed.*

Unlike Medicaid DSH payments, Puerto Rico is eligible for Medicare DSH payments. And in contrast to Medicaid DSH payments, which vary by State, Medicare DSH payments are based upon a standard national formula, a component of which is the wage index. Because of the manner in which the formula is applied, Puerto Rico's Medicare DSH payments are suppressed by what is known as the "wage index spiral". This phenomenon has been described by MedPac as one in which hospitals that successfully moderate increases in hourly wages relative to the national average increase will see a decrease in their wage index, and therefore their DSH payments: "They will then receive lower payments, which may create pressure to exert even tighter control over costs . . . If hospitals succeed at keeping wage increases below the national average again, their wage index could decrease still further." (MedPAC, Report to the Congress: Promoting Greater Efficiency in Medicare, pg. 130 (June 2007))

Puerto Rico is particularly susceptible to this spiraling effect. As recently stated by the Medicaid and Medicare Advantage Product Association of Puerto Rico (MMPA) and the Puerto Rico Hospital Association in their June 24, 2019 joint letter to CMS (attached), wages for Puerto Rico in general are reported to be significantly lower than the national average. The cost of living in Puerto Rico, however, is comparable

to that of the United States, and in fact the 55th costliest area out of 297 examined Metropolitan Statistical Areas in the U.S., with higher prices than the U.S. average in most categories. (see Institute of Statistics of Puerto Rico, Cost of Living Index, (https://estadisticas.pr/files/inventario/indice_de_costo_de_vida/2017-12-21/One_pager_COLI%202016Q3_2017Q3.pdf).

Due to comparatively low Medicare reimbursements and rising nonlabor costs, hospitals in Puerto Rico must therefore keep wages low, which feeds into the "wage index spiral" described above.

In general terms, Medicare DSH payments are generally available only to acute care hospitals that participate in the Medicare inpatient prospective payment system and whose percentage of low-income patients is above 15 percent. The Medicare program uses the number of Medicaid patient days as a percentage of total patient days plus the number of Supplemental Security Income (SSI) Medicare patient days as a share of Medicare patient days to calculate a hospital's percentage of low-income patients. This means that in the States, SSI patients with both Medicaid and Medicare are weighted more heavily. However, because residents of Puerto Rico are ineligible for SSI, a proxy is used in the calculation of DSH payments for uncompensated care.

Under Medicare, hospitals may also be eligible for Medicare DSH payments under alternative criteria established by federal law. Under federal alternative criteria, hospitals are eligible for Medicare DSH payments if they: are located in an urban area; have 100 or more beds; and can demonstrate that more than 30 percent of their revenue comes from state and local government payments for care provided to low-income patients not covered by Medicare or Medicaid.

Medicare DSH payments flow directly from the federal government to individual hospitals as increases to the hospital's normal diagnostic-related group (DRG) payments. The payment increase varies from hospital to hospital, and depends on a number of factors, including a hospital's bed count and its location. Although the Affordable Care Act implemented additional changes to the DSH payment system, the above provides a general understanding of the concepts applicable to the same.